Behavioral & psychological symptoms of dementia

Wisconsin Public Psychiatry Network Teleconference

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Outline

- dementia: definition, causes and course
- behavioral & psychological symptoms of dementia (BPSD)
- evaluation of BPSD
- psychosocial interventions
- psychopharmacological interventions
- summary: multifaceted treatment plan

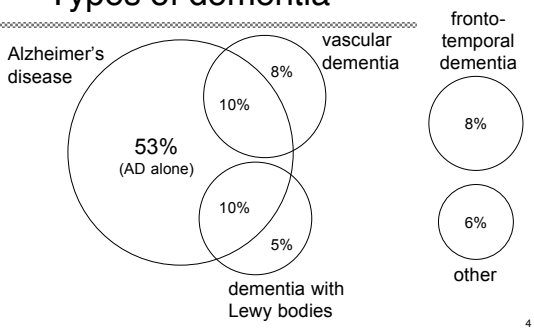
2

DSM-IV-TR dementia diagnostic criteria

- A. Multiple cognitive deficits, including both:
  - Memory impairment, and
  - At least one of the following: aphasia, apraxia, agnosia, disturbance in executive functioning
- B. Significant functional impairment
- C. Course: gradual onset, continuing decline

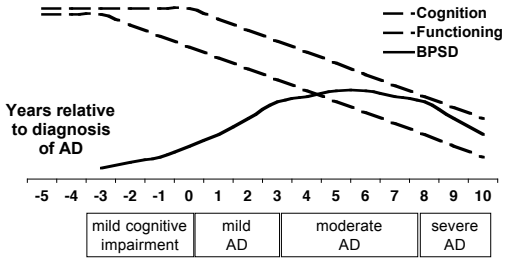
3

Types of dementia



4

Course of Alzheimer's disease



5

What are BPSD?

- paranoia and delusions
  - delusions of theft
  - home is not one's own
  - caregiver is an imposter or unfaithful
- hallucinations
- agitation
  - physically non-aggressive behavior
  - physically aggressive behavior
  - verbal behavior

6

What are BPSD?

- repetitive behavior
  - verbal
  - physical
- depression
- anxiety
- sleep disturbance
- resistance to activities of daily living

7

BPSD are associated with poor outcomes

- ↓ ability to care for self
- caregiver burden, depression & anxiety
- ↓ time to institutionalization
- ↑ direct economic costs
- ↓ survival
- ↓ quality of life
- ? ↑ risk of abuse/neglect

Finkel *Clin Geriatr Med* 2003; 19: 799-824.

8

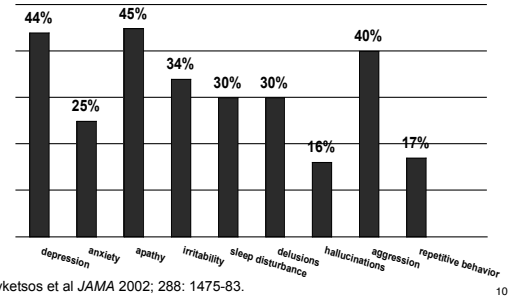
BPSD are very common

	community sample of 362 people with dementia
cumulative prevalence: since onset of illness	80%
point prevalence: over the last month	62%

Lyketsos et al *JAMA* 2002; 288: 1475-83.

9

Cumulative prevalence of specific BPSD



Lyketsos et al *JAMA* 2002; 288: 1475-83.

10

Evaluation tools

- history from caregivers
- behavioral observation
- screen for all BPSD
- screen for caregiver burden
- assess level of functioning (activities of daily living)

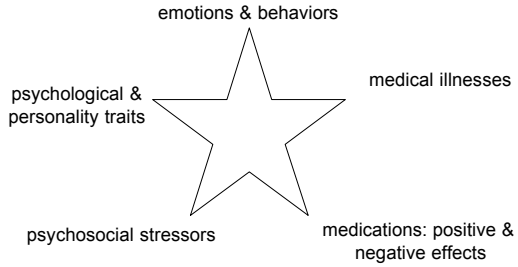
11

Functional assessment

- basic ADL's
  - dressing self
  - feeding self
  - walking
  - toileting
  - hygiene, e.g., bathing
- instrumental ADL's
  - shopping
  - housekeeping
  - finances
  - food preparation
  - transportation

12

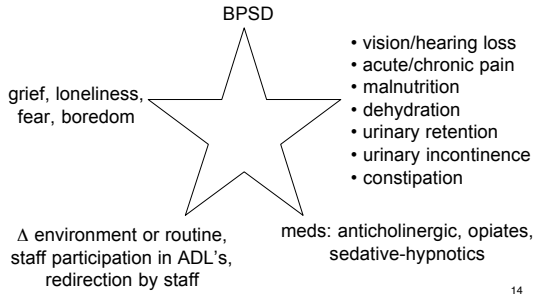
Wisconsin Star Method



Howell, *18th Annual Meeting of the AAGP* 2005, San Diego

13

Wisconsin Star Method: BPSD



14

Overview of treatment strategy

- address underlying medical and medication factors
- caregiver education and training
- psychosocial interventions
- psychopharmacological interventions
  - if behavioral interventions have failed
- realistic goal: reduce severity of BPSD, not eliminate them

15

Caregivers and BPSD

- screen for caregiver burden
  - referral for psychiatric evaluation may be necessary
- education:
  - focus on changing interactions with patients
  - Alzheimer's Association
  - 24-hour helpline: 800-272-3900

Black & Almeida *Int Psychogeriatr* 2004;16(3):295-315.

16

Evidence-based psychosocial interventions

- behavioral management
- cognitive stimulation therapy
- psychoeducation for caregivers & staff
- music therapy (acute management)

Livingston et al *Am J Psychiatry* 2005; 162:1996-2021.

17

Behavioral interventions: overview

- **consistent environment:**
  - non-stressful, constant, familiar
  - soft lighting, calm colors, carpeting
- **consistent schedule:**
  - stable - change routine only gradually
  - promote sleep - increase daytime activity, appropriate cues, adequate lighting & sound

18

Behavioral analysis

- **identify**: what is the problem behavior?
- **timing:** when does it happen?
- **surroundings:** where does it happen?
- **others:** who else is involved?
- **very troubling:** how dangerous?
- **evaluation:** what else might be causing it?
- **recommend:** how do I respond?

Gray *Clin Geriatr Med* 2004; 20: 69-82.

19

Pharmacological interventions

- categories:
  - atypical antipsychotics - best evidence
  - antidepressants - some evidence
  - cognitive enhancers - some evidence
  - anticonvulsants - mixed results
  - typical antipsychotics - not used
  - sedative-hypnotics - serious side effects
- in general, modest benefits with significant potential for side effects
- all choices are off-label usages

20

Efficacy of atypical antipsychotics

- small effect on behavioral symptoms
- significant placebo effects
- NNT = 6 patients must be treated for 1 to respond
- response usually in first 2-4 weeks
- high rates of discontinuation

Schneider et al *Am J Geriatr Psych* 2006; 14:191-210.

21

Atypical antipsychotics: safety

- extrapyramidal symptoms
- diabetes and dyslipidemia[1]
- cerebrovascular adverse events[2]
- mortality[3]
- cognitive impairment
- falls
- sedation
- QT prolongation

FDA warnings: [1]Sept 2003, [2]April 2003 & Jan 2004, [3]April 2005.

22

Monitoring of antipsychotic treatment

- optimal follow-up:
  - after starting an antipsychotic: 7-14 days
  - after change in dosage: 10 days - 4 weeks
  - after patient stable for 1 month: 2-3 months
  - maintenance: every 3-6 months
- optimal interval for dose changes: 5-7 days
- optimal duration of treatment:
  - if ineffective: discontinue by 4-6 weeks
  - if effective: begin to taper by 3-6 months
- OBRA regulations

Alexopoulos et al *J Clin Psychiatry* 2004; 65 (suppl 2): 1-105.

23

Summary of non-antipsychotic treatment options

- **antidepressants:** smaller database than antipsychotics, but may be safer
- **anticonvulsants:** questions about efficacy, tolerability and drug-drug interactions
- **cognitive enhancers:** modest benefit, patients should probably already be on these medications anyway
- **sedative-hypnotics:** risks generally outweigh benefits

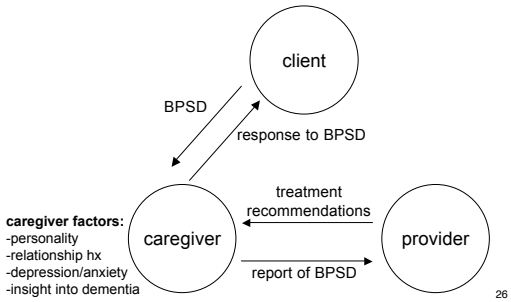
24

Multifaceted treatment approach

- assess BPSD and contributing factors
- address caregiver issues
- start with psychosocial interventions
- judiciously proceed to medication interventions:
  - antipsychotic or SSRI (or anticonvulsant)
  - if not on cognitive enhancer and no contraindication, start one
- monitor and regularly reassess use of medications

25

BPSD: client, caregiver & you



26